Provider *Insider*

Alabama Medicaid Bulletin **March 2006**

The checkwrite schedule is as follows:

03/03/06 03/17/06 04/07/06 04/21/06

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid and MASA Identify Code Sets for Audit Process

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(Continued on Page 7)

In This Issue...

Pass It On!

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- ❒ *Office Manager*
- ❒ *Billing Dept.*
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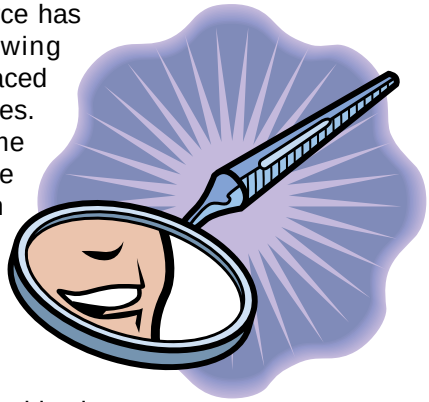

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Post and cores, each additional (D2953, D2957) are limited to 2 per date of service individually or in combination.

Pulpotomy (D3220) and Pulpal Therapy (D3230, D3240) procedures are limited to 6 per date of service individually or in combination.

Root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination.

Molar root canals (D3330) are limited to 2 per date of service. One molar root canal can be performed with 3 anterior or premolar root canal procedures.

If you have questions, you can call 334-242-5472.

Submission of Sterilization Consent Form is Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to EDS. Providers other than performing surgeon should not submit a copy of consent form to EDS. Receipt of multiple consent forms slows down the consent form review process and payment of claims. Therefore, do not forward copies of completed consent forms to other providers for submission to EDS.

When the claim for the sterilization procedure is submitted to EDS, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

Therefore, it is imperative that the Primary Surgeon get the completed consent form submitted to EDS in a timely manner so that other providers involved in the sterilization procedure can get reimbursed for their services.

Attention Hospital Providers

When adjusting claims that previously paid as a Maternity Encounter (Plan Code PXX) or as a crossover to a PHP Encounter (Plan Code HXX), you must completely reverse the claim out of the system and resubmit it. The PHP does not receive maternity encounter claims or crossover claim information. If the claim is simply adjusted, then the PHP does not have the correct information to process the PHP encounter claim. In fact, there have been instances where hospitals have actually had money recouped that was never paid to begin with because of adjustments appearing on their EOPs. To keep claims processing correctly, please remember to REVERSE these claims not adjust them.

Revenue Code 128 (room and board, semi-private, 2-bed rehabilitation) is not a covered revenue code. Hospitals have requested that this code be added to recognize the placement of patients in these type beds while receiving acute care services in addition to rehab services. This code WILL NOT BE ADDED in that adult inpatient rehab services are not a covered benefit. If a hospital has a person in this type bed and is receiving acute care services in addition to rehab services, it is acceptable for Medicaid billing to use a covered revenue code to indicate room and board.

Code Changes for Therapy Providers

Effective January 1, 2006, the following CPT codes have changed: The old codes will no longer be valid after December 31, 2005.

Old Code	New Code
97504	97760
97520	97761
97703	97662

Please note that 97760 should not be reported with 97116 for the same extremity. Please refer to your provider manual, Chapter 37, for additional information.

Change for Oxaliplatin/Eloxatin

Oxaliplatin/Eloxatin (J9263) for injection is now diagnosis restricted. The diagnosis codes that support Medical Necessity are 153.0 – 154.8.

Billing for Space Maintainers

The claim must show the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. Providers should bill the tooth extracted.

Hospice Program Changes

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission for the hospice program. The reviews include hospice stays of six months or more. The LTC Admissions Records Unit will submit dates of service to the LTC file for hospice admission or recertification. Pediatric cases and other diagnoses not found in the Administrative Code Rule 560-X-51-04 are reviewed on a case by case basis.

When a recipient meets the medical criteria for the Medicaid hospice benefit the provider must mail the Hospice Program Cover Sheet, Form 165, and any supporting documentation such as diagnoses, medications, nurse's notes, laboratory reports or other information to:

Alabama Medicaid Agency
Long Term Care Admissions/Records
501 Dexter Avenue
Montgomery, AL 36104

The processing time for an application is approximately 30 days. After the review is completed, notification of acceptance is faxed or denials mailed to the provider within 48 hours. For additional information visit the Medicaid website at *www.medicaid.alabama.gov*.

Medical Necessity for Procedures and Surgeries

The Alabama Medicaid Agency is mandated to only reimburse for services, procedures, and surgeries that are medically necessary. Medical necessity must be documented in the recipient's medical record with supporting documentation such as: Laboratory test results, diagnostic test results, history (past attempts of management if applicable), signs and symptoms, etc.. All Medicaid services are subject to retrospective review for medical necessity.

EXAMPLE:

Endometrial Ablation is covered by Medicaid when it is considered medically necessary and should not be performed when alternative outcome is intended such as cessation of menses. Medical necessity must be clearly documented in the medical record.

Immune Globulin Replacement Codes

Effective for dates of service January 1, 2006 and thereafter, Intravenous Immune Globulin has new codes. The codes are listed below for reference and may be viewed on the Physician Drug Fee Schedule on our website at *www.medicaid.alabama.gov*.

HCPCs Code	Long Description	Max Units
J1566	Injection, Immune Globulin, Intravenous, Lyophilized, (e.g. powder), 500 mg.	140
J1567	Injection, Immune Globulin, Intravenous, Non-Lyophilized, (e.g. liquid), 500 mg	140

Previous HCPCs Codes: Q9941, Q9942, Q9943, and Q9944 have been discontinued effective December 31, 2005.

Hospice Quarterly Random Reviews

On January 1, 2006, Hospice Providers billing an inappropriate nursing home rate will be required to adjust these claims or be subject to recoupment of the inappropriately billed claim.

During FY 2005 and the first quarter of FY 2006 the LTC Provider/Recipients Services conducted random reviews of the claims for each hospice provider to ensure the appropriate nursing home reimbursement rate was billed. Hospice providers must bill 95% of the nursing home rate for the facility where the recipient resides and receives hospice care.

Compound Drugs

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Updated Adjustment Request Form Available

A new adjustment request form is now available for you to complete paper adjustments. The form can be found in Appendix E of your provider manual. Your provider manual is sent to you each quarter via CD-ROM. The Provider Manual may also be found on the website. Our address is: *www.medicaid.gov.* The specific link to the new form is: *http://www.medicaid.alabama.gov/documents/Billing/5-G_Manuals/5G-2_Provider.Manual_Jan.2006/Jan06_E.pdf.*

Please destroy all copies of the old form and begin utilizing this form. We have updated the form to make it easier for you to identify what services you would like to change.

You may also submit adjustment requests via our Provider Electronic Solutions software. If you are currently submitting paper adjustments, and would like more information on how to complete adjustments via our software, contact your Provider Representative at 1-800-688-7989.

www.medicaid.state.al.us

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Updated Vaccine For Children (VFC) Codes

The VFC Program has added two new codes (90633-Hepatitis A and 90636 Hepatitis A & B) effective February 1, 2006. The current list of available VFC codes with effective dates is listed below for your information and convenience. Please share this information with your billing staff. For more information concerning the new codes, please contact the VFC Program at 1-800-469-4599.

CPT-4 Procedure Code	Immunization
90633	Hepatitis A, 2-does pediatric formula (12months – 18 years of age) – Eff. 2/1/06
90636	Hepatitis A & B – e-dose formulation (18 years of age only), - Eff. 2/1/06
90645	Haemophilus influenzae type b (Hibtiter)
90647	Haemophilus influenzae type b (Pedvax)
90648	Haemophilus influenzae type b (ActHib)
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Haemophilus influenzae, split virus, preservative free (3 years and older)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 yrs of age) – Eff. 9/6/05
90713	Poliomeylitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05
90716	Varicella (Chicken pox) vaccine (for selected recipients)
90718	Tetanus and Diptheria (Td) (for adult use)
90721	Diphtheria, Tetanus, Acellular Pertussis and Hemophilus influenzae b (DTaP-HIB)
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Memingococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and Hemophilus influenzae b (Hep B-Hib)

Patient 1st Information

Patient 1st Providers now have the capability to download files electronically. If you are interested in receiving electronic files, please contact the EMS Helpdesk at 1-800-456-1242 for instructions on usage and how to create a password. The files currently available for download are the Patient 1st Roster (PT1) and the Patient 1st Assignment List (PT5).

TPL Policy on EPSDT / Preventive Services

Medicaid is a secondary payer to all available third party resources, with the exception of EPSDT (initial and periodic screenings) / Preventive Services (immunizations), unless the patient is enrolled in a managed care plan/HMO or Medicaid pays the provider on an encounter or capitation basis. This does not apply when billing for interperiodic screenings (procedure codes 99391-99395-without an EP modifier). The patient's other insurance must be filed first when billing for interperiodic screenings.

Visit Alabama Medicaid

ONLINE

www.medicaid.state.al.us

Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Obtain Current Medicaid Press Releases and Bulletins**
- **Obtain Billing and Provider Manuals and Other General Information about Medicaid**

New Codes for Plan First

Beginning January 2006, Plan First Providers will need to use procedure code J7304 with the appropriate modifier (see below) when filing claims for the Ortho Evra Patch instead of procedure code J3490 SE. This change is due to HCPCS update.

- Private enrolled Plan First Providers will submit a claim for the dispensing fee using procedure code J7304. This procedure code is TPL exempt.
- Health Department Providers will submit a claim for reimbursement using procedure code J7304 with modifier FP. This procedure code with modifier is TPL exempt.
- FQHCs, PBRHCs & IRHCs will submit a claim for reimbursement using procedure code J7304 with modifier SE for the Ortho Evra Patch and S4993 with modifier SE for the oral contraceptives and these codes will be zero paid. NOTE: This will eliminate the need for quarterly distribution updates to be sent to the Plan First Program Manager and will ensure that Medicaid has the information to receive the Federal Match.

NOTE: The updated (10/04) Contraceptive Order Form and Log is available on the Medicaid website at *www.medicaid.state.al.us* and can be found under the "Programs/Plan First" sections. If you do not have access to the web, you may contact the Program Manager at 334-353-5263 to receive a faxed copy.

Reminder: The oral contraceptives and the ortho evra patches that you dispense are for Plan First recipients only!

Full Medicaid recipients may have their prescriptions filled at a pharmacy.

Lab Tests Performed In Physician's Offices

When performing laboratory tests in the physician's office:

1. The Physician must be CLIA certified to perform the test,
2. The Physician must have the appropriate equipment to perform the test, and
3. The Physician's office bills for the tests performed but not the collection fee.

When Physician Offices send specimens to an outside lab:

1. The Physician's office should not bill the laboratory code, and
2. The Physician's office may bill a collection fee with a "90" modifier for blood specimens.

EXAMPLE: Lead Levels

Procedure Code 83655 (Lead) should only be billed when the office has the equipment to perform the test. When collecting a specimen only and then sending the blood sample to an outside lab for analysis, you must bill Procedure Code 36415 with modifier 90. The utilization of Procedure code 36415-90 will enable you to receive a collection and handling fee for the specimen obtained.

Procedure Code 36415-90 should not be billed when lab procedures are performed in the office. The appropriate lab procedure code(s) must be billed when actually performing the lab test. Again, the correct equipment must be utilized to perform the test. These services are subject to post-payment review. Medical record documentation must support the performance and medical necessity of the laboratory test.

Evaluation And Management Codes Billed In Conjunction With Drug Administration Codes

When an Evaluation and Management Code (E & M) is billed, medical record documentation must support the medical necessity of the visit as well as the level of care provided. CPT Guidelines are utilized to determine if the key components of an Evaluation and Management Code are met. When an Evaluation and Management service is provided and a Drug Administration code (90772, 90773, 90774, and 90775) is provided at the same time, the E & M Code, Drug Administration Code, and the HCPCs Code for the drug may be billed.

However, when no E & M service is actually provided at the time of a Drug Administration, an E & M Code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without an E & M service being provided.

There have been 2006 CPT Code changes to describe other Administration Codes for Hydration (90760, 90761), Therapeutic, Prophylactic, and Diagnostic Infusions (90765, 90766, 90767, 90768) and Chemotherapy Administration Codes (96401-96542). A Significant Separately Identifiable Service must be performed in conjunction with these administration codes for consideration of payment for an Evaluation and Management Code to occur. A Modifier 25 must be appended to the E & M service for recognition as a "Significant Separately Identifiable Service". Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

Medicaid and MASA Identify Code Sets for Audit Process **(Continued from Page 1)**

CODE SETS	**MULTIPLE SURGERY**
Right Heart Cath and Cath Placement 93526 and 36245	Yes
Bronchoscopy and Laryngscopy 31622-31525	Yes
Heart Cath and Endomyocardial Biopsy 93501 and 93505	Yes
Stents 92980 and 92981	No
Nerve block/Circumcision 54150 and 64450	Yes
Layer Closures 11000-11646; 12031-12057; 13100-13160	Yes
Cultures 87086 – 87070, 87086 – 87071 and 87086 – 87073	No
Venous vs. Arterial Codes 36600 and 36000	Yes
Chest x-ray code range (71010-71035) and abdomen range (74000-74022)	No
93975 duplex scan and 76770 US retroperitoneal ultrasound	No
Operating Microscope 69990 (application of CPT rules instead of CCI. Effective 1/1/05, Medicare guidelines were applied)	No
Tympanostomy 69436 – codes below: Allowed with	Yes

69436	11900	21030	30545	31238	31511	31615	40819	42720	42831
11300	12052	21555	30801	31240	31515	31622	40820	42806	42835
11305	14040	21556	30802	31254	31525	31624	41010	42810	42836
11401	15120	30115	30901	31255	31526	31625	41110	42815	42870
11420	15760	30130	30903	31256	31535	31641	41115	42820	42960
11440	17000	30140	31000	31267	31540	38510	41520	42821	42961
11441	17017	30200	31020	31276	31541	38542	42140	42825	43200
11444	17250	30310	31231	31287	31575	38724	42145	42826	43202
11900	20922	30520	31237	31288	31613	40808	42200	42830	43830

Things to Know:

- HWT will generate new letters for providers affected by these code set changes.
- The letters will be mailed the week of January 30, 2006 and will reflect the adjusted amount of overpayment. Providers will have 60 days from the date of the revised letter to contact HWT with dispute documentation.
- Providers will not get a new letter if these specific codes sets were not identified in their original letter. Providers not receiving a revision letter have until March 1, 2006, to submit documentation in dispute to HWT.
- If a provider has already made payment in full, Medicaid submitted a refund to these providers on the February 17th checkwrite if their original overpayment contained any of these code sets.

State Fiscal Year 2005-2006 Checkwrite Schedule

~~10/07/05~~	~~01/06/06~~	04/07/06	07/07/06
~~10/21/05~~	~~01/20/06~~	04/21/06	07/21/06
~~11/04/05~~	~~02/03/06~~	05/05/06	08/04/06
~~11/18/05~~	~~02/17/06~~	05/19/06	08/18/06
~~12/09/05~~	03/03/06	06/02/06	09/08/06
~~12/16/05~~	03/17/06	06/16/06	09/15/06

Alabama Medicaid Bulletin

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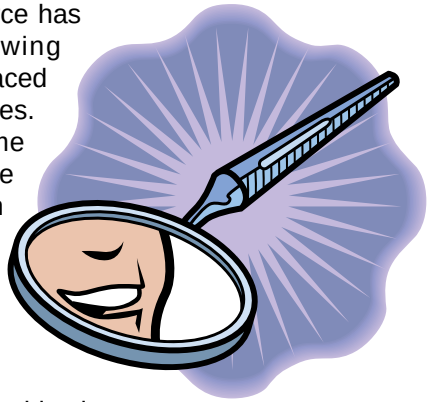

Permanent, stainless steel or resin crowns are limited to 6 per date of service individually or in combination. These procedure codes include D2750, D2751, D2752, D2792, D2930, D2931 and D2932.

Core buildups (D2950) and post and cores (D2952, D2954) are limited to 6 per date of service individually or in combination.

Post and cores, each additional (D2953, D2957) are limited to 2 per date of service individually or in combination.

Pulpotomy (D3220) and Pulpal Therapy (D3230, D3240) procedures are limited to 6 per date of service individually or in combination.

Root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination.

Molar root canals (D3330) are limited to 2 per date of service. One molar root canal can be performed with 3 anterior or premolar root canal procedures.

If you have questions, you can call 334-242-5472.

Submission of Sterilization Consent Form is Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to EDS. Providers other than performing surgeon should not submit a copy of consent form to EDS. Receipt of multiple consent forms slows down the consent form review process and payment of claims. Therefore, do not forward copies of completed consent forms to other providers for submission to EDS.

When the claim for the sterilization procedure is submitted to EDS, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

Therefore, it is imperative that the Primary Surgeon get the completed consent form submitted to EDS in a timely manner so that other providers involved in the sterilization procedure can get reimbursed for their services.

Attention Hospital Providers

When adjusting claims that previously paid as a Maternity Encounter (Plan Code PXX) or as a crossover to a PHP Encounter (Plan Code HXX), you must completely reverse the claim out of the system and resubmit it. The PHP does not receive maternity encounter claims or crossover claim information. If the claim is simply adjusted, then the PHP does not have the correct information to process the PHP encounter claim. In fact, there have been instances where hospitals have actually had money recouped that was never paid to begin with because of adjustments appearing on their EOPs. To keep claims processing correctly, please remember to REVERSE these claims not adjust them.

Revenue Code 128 (room and board, semi-private, 2-bed rehabilitation) is not a covered revenue code. Hospitals have requested that this code be added to recognize the placement of patients in these type beds while receiving acute care services in addition to rehab services. This code WILL NOT BE ADDED in that adult inpatient rehab services are not a covered benefit. If a hospital has a person in this type bed and is receiving acute care services in addition to rehab services, it is acceptable for Medicaid billing to use a covered revenue code to indicate room and board.

Code Changes for Therapy Providers

Effective January 1, 2006, the following CPT codes have changed: The old codes will no longer be valid after December 31, 2005.

Old Code	New Code
97504	97760
97520	97761
97703	97662

Please note that 97760 should not be reported with 97116 for the same extremity. Please refer to your provider manual, Chapter 37, for additional information.

Change for Oxaliplatin/Eloxatin

Oxaliplatin/Eloxatin (J9263) for injection is now diagnosis restricted. The diagnosis codes that support Medical Necessity are 153.0 – 154.8.

Billing for Space Maintainers

The claim must show the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. Providers should bill the tooth extracted.

Hospice Program Changes

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission for the hospice program. The reviews include hospice stays of six months or more. The LTC Admissions Records Unit will submit dates of service to the LTC file for hospice admission or recertification. Pediatric cases and other diagnoses not found in the Administrative Code Rule 560-X-51-04 are reviewed on a case by case basis.

When a recipient meets the medical criteria for the Medicaid hospice benefit the provider must mail the Hospice Program Cover Sheet, Form 165, and any supporting documentation such as diagnoses, medications, nurse's notes, laboratory reports or other information to:

Alabama Medicaid Agency
Long Term Care Admissions/Records
501 Dexter Avenue
Montgomery, AL 36104

The processing time for an application is approximately 30 days. After the review is completed, notification of acceptance is faxed or denials mailed to the provider within 48 hours. For additional information visit the Medicaid website at *www.medicaid.alabama.gov*.

Medical Necessity for Procedures and Surgeries

The Alabama Medicaid Agency is mandated to only reimburse for services, procedures, and surgeries that are medically necessary. Medical necessity must be documented in the recipient's medical record with supporting documentation such as: Laboratory test results, diagnostic test results, history (past attempts of management if applicable), signs and symptoms, etc.. All Medicaid services are subject to retrospective review for medical necessity.

EXAMPLE:

Endometrial Ablation is covered by Medicaid when it is considered medically necessary and should not be performed when alternative outcome is intended such as cessation of menses. Medical necessity must be clearly documented in the medical record.

Immune Globulin Replacement Codes

Effective for dates of service January 1, 2006 and thereafter, Intravenous Immune Globulin has new codes. The codes are listed below for reference and may be viewed on the Physician Drug Fee Schedule on our website at *www.medicaid.alabama.gov*.

HCPCs Code	Long Description	Max Units
J1566	Injection, Immune Globulin, Intravenous, Lyophilized, (e.g. powder), 500 mg.	140
J1567	Injection, Immune Globulin, Intravenous, Non-Lyophilized, (e.g. liquid), 500 mg	140

Previous HCPCs Codes: Q9941, Q9942, Q9943, and Q9944 have been discontinued effective December 31, 2005.

Hospice Quarterly Random Reviews

On January 1, 2006, Hospice Providers billing an inappropriate nursing home rate will be required to adjust these claims or be subject to recoupment of the inappropriately billed claim.

During FY 2005 and the first quarter of FY 2006 the LTC Provider/Recipients Services conducted random reviews of the claims for each hospice provider to ensure the appropriate nursing home reimbursement rate was billed. Hospice providers must bill 95% of the nursing home rate for the facility where the recipient resides and receives hospice care.

Compound Drugs

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Updated Adjustment Request Form Available

A new adjustment request form is now available for you to complete paper adjustments. The form can be found in Appendix E of your provider manual. Your provider manual is sent to you each quarter via CD-ROM. The Provider Manual may also be found on the website. Our address is: *www.medicaid.gov.* The specific link to the new form is: *http://www.medicaid.alabama.gov/documents/Billing/5-G_Manuals/5G-2_Provider.Manual_Jan.2006/Jan06_E.pdf.*

Please destroy all copies of the old form and begin utilizing this form. We have updated the form to make it easier for you to identify what services you would like to change.

You may also submit adjustment requests via our Provider Electronic Solutions software. If you are currently submitting paper adjustments, and would like more information on how to complete adjustments via our software, contact your Provider Representative at 1-800-688-7989.

www.medicaid.state.al.us

ALABAMA MEDICAID

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Updated Vaccine For Children (VFC) Codes

The VFC Program has added two new codes (90633-Hepatitis A and 90636 Hepatitis A & B) effective February 1, 2006. The current list of available VFC codes with effective dates is listed below for your information and convenience. Please share this information with your billing staff. For more information concerning the new codes, please contact the VFC Program at 1-800-469-4599.

CPT-4 Procedure Code	Immunization
90633	Hepatitis A, 2-does pediatric formula (12months – 18 years of age) – Eff. 2/1/06
90636	Hepatitis A & B – e-dose formulation (18 years of age only), - Eff. 2/1/06
90645	Haemophilus influenzae type b (Hibtiter)
90647	Haemophilus influenzae type b (Pedvax)
90648	Haemophilus influenzae type b (ActHib)
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Haemophilus influenzae, split virus, preservative free (3 years and older)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 yrs of age) – Eff. 9/6/05
90713	Poliomeylitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05
90716	Varicella (Chicken pox) vaccine (for selected recipients)
90718	Tetanus and Diptheria (Td) (for adult use)
90721	Diphtheria, Tetanus, Acellular Pertussis and Hemophilus influenzae b (DTaP-HIB)
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Memingococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and Hemophilus influenzae b (Hep B-Hib)

Patient 1st Information

Patient 1st Providers now have the capability to download files electronically. If you are interested in receiving electronic files, please contact the EMS Helpdesk at 1-800-456-1242 for instructions on usage and how to create a password. The files currently available for download are the Patient 1st Roster (PT1) and the Patient 1st Assignment List (PT5).

TPL Policy on EPSDT / Preventive Services

Medicaid is a secondary payer to all available third party resources, with the exception of EPSDT (initial and periodic screenings) / Preventive Services (immunizations), unless the patient is enrolled in a managed care plan/HMO or Medicaid pays the provider on an encounter or capitation basis. This does not apply when billing for interperiodic screenings (procedure codes 99391-99395-without an EP modifier). The patient's other insurance must be filed first when billing for interperiodic screenings.

Visit Alabama Medicaid

ONLINE

www.medicaid.state.al.us

Providers can :

- **Print Forms and Enrollment Applications**
- **Download Helpful Software**
- **Obtain Current Medicaid Press Releases and Bulletins**
- **Obtain Billing and Provider Manuals and Other General Information about Medicaid**

New Codes for Plan First

Beginning January 2006, Plan First Providers will need to use procedure code J7304 with the appropriate modifier (see below) when filing claims for the Ortho Evra Patch instead of procedure code J3490 SE. This change is due to HCPCS update.

- Private enrolled Plan First Providers will submit a claim for the dispensing fee using procedure code J7304. This procedure code is TPL exempt.
- Health Department Providers will submit a claim for reimbursement using procedure code J7304 with modifier FP. This procedure code with modifier is TPL exempt.
- FQHCs, PBRHCs & IRHCs will submit a claim for reimbursement using procedure code J7304 with modifier SE for the Ortho Evra Patch and S4993 with modifier SE for the oral contraceptives and these codes will be zero paid. NOTE: This will eliminate the need for quarterly distribution updates to be sent to the Plan First Program Manager and will ensure that Medicaid has the information to receive the Federal Match.

NOTE: The updated (10/04) Contraceptive Order Form and Log is available on the Medicaid website at *www.medicaid.state.al.us* and can be found under the "Programs/Plan First" sections. If you do not have access to the web, you may contact the Program Manager at 334-353-5263 to receive a faxed copy.

Reminder: The oral contraceptives and the ortho evra patches that you dispense are for Plan First recipients only!

Full Medicaid recipients may have their prescriptions filled at a pharmacy.

Lab Tests Performed In Physician's Offices

When performing laboratory tests in the physician's office:

1. The Physician must be CLIA certified to perform the test,
2. The Physician must have the appropriate equipment to perform the test, and
3. The Physician's office bills for the tests performed but not the collection fee.

When Physician Offices send specimens to an outside lab:

1. The Physician's office should not bill the laboratory code, and
2. The Physician's office may bill a collection fee with a "90" modifier for blood specimens.

EXAMPLE: Lead Levels

Procedure Code 83655 (Lead) should only be billed when the office has the equipment to perform the test. When collecting a specimen only and then sending the blood sample to an outside lab for analysis, you must bill Procedure Code 36415 with modifier 90. The utilization of Procedure code 36415-90 will enable you to receive a collection and handling fee for the specimen obtained.

Procedure Code 36415-90 should not be billed when lab procedures are performed in the office. The appropriate lab procedure code(s) must be billed when actually performing the lab test. Again, the correct equipment must be utilized to perform the test. These services are subject to post-payment review. Medical record documentation must support the performance and medical necessity of the laboratory test.

Evaluation And Management Codes Billed In Conjunction With Drug Administration Codes

When an Evaluation and Management Code (E & M) is billed, medical record documentation must support the medical necessity of the visit as well as the level of care provided. CPT Guidelines are utilized to determine if the key components of an Evaluation and Management Code are met. When an Evaluation and Management service is provided and a Drug Administration code (90772, 90773, 90774, and 90775) is provided at the same time, the E & M Code, Drug Administration Code, and the HCPCs Code for the drug may be billed.

However, when no E & M service is actually provided at the time of a Drug Administration, an E & M Code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without an E & M service being provided.

There have been 2006 CPT Code changes to describe other Administration Codes for Hydration (90760, 90761), Therapeutic, Prophylactic, and Diagnostic Infusions (90765, 90766, 90767, 90768) and Chemotherapy Administration Codes (96401-96542). A Significant Separately Identifiable Service must be performed in conjunction with these administration codes for consideration of payment for an Evaluation and Management Code to occur. A Modifier 25 must be appended to the E & M service for recognition as a "Significant Separately Identifiable Service". Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

Medicaid and MASA Identify Code Sets for Audit Process **(Continued from Page 1)**

CODE SETS	**MULTIPLE SURGERY**
Right Heart Cath and Cath Placement 93526 and 36245	Yes
Bronchoscopy and Laryngscopy 31622-31525	Yes
Heart Cath and Endomyocardial Biopsy 93501 and 93505	Yes
Stents 92980 and 92981	No
Nerve block/Circumcision 54150 and 64450	Yes
Layer Closures 11000-11646; 12031-12057; 13100-13160	Yes
Cultures 87086 – 87070, 87086 – 87071 and 87086 – 87073	No
Venous vs. Arterial Codes 36600 and 36000	Yes
Chest x-ray code range (71010-71035) and abdomen range (74000-74022)	No
93975 duplex scan and 76770 US retroperitoneal ultrasound	No
Operating Microscope 69990 (application of CPT rules instead of CCI. Effective 1/1/05, Medicare guidelines were applied)	No
Tympanostomy 69436 – codes below: Allowed with	Yes

69436	11900	21030	30545	31238	31511	31615	40819	42720	42831
11300	12052	21555	30801	31240	31515	31622	40820	42806	42835
11305	14040	21556	30802	31254	31525	31624	41010	42810	42836
11401	15120	30115	30901	31255	31526	31625	41110	42815	42870
11420	15760	30130	30903	31256	31535	31641	41115	42820	42960
11440	17000	30140	31000	31267	31540	38510	41520	42821	42961
11441	17017	30200	31020	31276	31541	38542	42140	42825	43200
11444	17250	30310	31231	31287	31575	38724	42145	42826	43202
11900	20922	30520	31237	31288	31613	40808	42200	42830	43830

Things to Know:

- HWT will generate new letters for providers affected by these code set changes.
- The letters will be mailed the week of January 30, 2006 and will reflect the adjusted amount of overpayment. Providers will have 60 days from the date of the revised letter to contact HWT with dispute documentation.
- Providers will not get a new letter if these specific codes sets were not identified in their original letter. Providers not receiving a revision letter have until March 1, 2006, to submit documentation in dispute to HWT.
- If a provider has already made payment in full, Medicaid submitted a refund to these providers on the February 17th checkwrite if their original overpayment contained any of these code sets.

State Fiscal Year 2005-2006 Checkwrite Schedule

~~10/07/05~~	~~01/06/06~~	04/07/06	07/07/06
~~10/21/05~~	~~01/20/06~~	04/21/06	07/21/06
~~11/04/05~~	~~02/03/06~~	05/05/06	08/04/06
~~11/18/05~~	~~02/17/06~~	05/19/06	08/18/06
~~12/09/05~~	03/03/06	06/02/06	09/08/06
~~12/16/05~~	03/17/06	06/16/06	09/15/06

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